MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

MT. PLEASANT CENTER

BUREAU OF HOSPITALS, CENTERS, AND FORENSIC
MENTAL HEALTH SERVICES
DEPARTMENT OF COMMUNITY HEALTH

April 2007

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0305-06

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit
Mt. Pleasant Center
Bureau of Hospitals, Centers, and Forensic Mental Health Services
Department of Community Health

Report Number:
391-0305-06

Released:
April 2007

The Center is the only State-operated facility serving individuals with developmental disabilities. The Center's mission is to empower individuals to achieve independence and personal aspirations. The Center subscribes to the person-centered planning process to treat patients, which is designed to enable patients to acquire, improve, and maintain skills leading toward greater independence. The Center is a certified participant in the Medicaid Intermediate Care Facility for Persons with Mental Retardation Program. As of June 30, 2006, the Center had 538 employees and 175 patients.

Audit Objective:
To assess the effectiveness of the Center's efforts to deliver selected patient care services.

Audit Conclusion:
We concluded that the Center was moderately effective in its efforts to deliver selected patient care services. We noted two material conditions (Findings 1 and 2) and three reportable conditions (Findings 3 through 5).

Material Conditions:
The Center needs to improve its monitoring of patient services to help ensure that the Center complies with patient treatment plans, Center policy, and State law and federal regulations (Finding 1).

The Center did not ensure that direct care staff received the training as required by Center policies and procedures. Also, the Center had not updated its training policies and procedures to help ensure that its training program meets the Center's operational needs. In addition, the Department of Community Health (DCH), in conjunction with the Center, had not developed an overall training strategy which would help the Center document its training practices. (Finding 2)

Reportable Conditions:
Our audit also disclosed reportable conditions related to person-centered planning process, dental care, and complaints (Findings 3 through 5).

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Audit Objective:
To assess the Center's efforts to safeguard and efficiently use selected resources.

Audit Conclusion:
We concluded that the Center's efforts were moderately effective in safeguarding and efficiently using selected resources. We noted two material conditions (Findings 6 and 7) and five reportable conditions (Findings 8 through 12).

Material Conditions:

The Center had not established effective controls over its inventories (Finding 6).

The Center did not effectively complete its biennial internal control assessment (Finding 7).

Reportable Conditions:

Our audit also disclosed reportable conditions related to medication purchases and utilization, medication refunds and rebates, patients' personal property, inventory of noncontrolled substances, and procurement card approvals (Findings 8 through 12).

Noteworthy Accomplishments:

In 1999, the Center, in conjunction with the Walter P. Reuther Psychiatric Hospital, entered into a 10-year energy management contract with a private vendor. The vendor installed equipment and systems for the purpose of reducing energy use and/or costs. The vendor charged the Center for the cost of the installation and guaranteed the Center and the Walter P. Reuther Psychiatric Hospital a minimum annual savings. For the first five years of the contract (2001 through 2005), the Center saved $883,916 over 1998 base year costs.

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Agency Responses:

Our audit report contains 12 findings and 19 corresponding recommendations. DCH's preliminary response indicated that DCH and the Center generally agreed with all 19 recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

April 10, 2007

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of the Mt. Pleasant Center, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; various exhibits, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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MT. PLEASANT CENTER
BUREAU OF HOSPITALS, CENTERS,
AND FORENSIC MENTAL HEALTH SERVICES
DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INFORMATION

GLOSSARY

Description of Agency

The Mt. Pleasant Center is an intermediate care facility for individuals with developmental disabilities*. The Center classifies patients as Medicaid eligible, non-Medicaid eligible, and incompetent to stand trial.

The Center, located in Isabella County, originated as the Michigan Home and Training School in 1934 to provide services to young men who had a mental illness*. The Center's name was changed a number of times from its formation until it assumed its current name in 1995. Over the years, the Center's focus also changed as it made the transition to becoming an intermediate care facility serving individuals with developmental disabilities. In August 2001, the Southgate Center discontinued providing care to individuals with developmental disabilities, leaving the Mt. Pleasant Center as the only State-operated facility serving these individuals.

The Center's mission* is to empower individuals to achieve independence and personal aspirations. The purpose of the Center is to provide short-term, residential-based supports and services to individuals with developmental disabilities until a viable community option is available.

The Center, as of June 2006, had the capacity to treat 272 patients. For fiscal years 1997-98 through 2004-05, the Center had an average daily census of 191 patients (see Exhibit 1). The Center's campus consists of 26 buildings, of which 3 are open residential units; 16 are used for maintenance, client services, administration, power generation, or staff housing; and 7 are closed.

The Center subscribes to the person-centered planning process* to treat patients. This process is designed to enable patients to acquire, improve, and maintain skills leading toward greater independence. The Center is a certified participant in the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Program. This certification allows the Center to be reimbursed by Medicaid for services provided to ICF/MR Program eligible patients. ICF/MR Program eligibility is based on the assessment of patient's deficiencies with completing daily living skills. As of June 30, 2006, the Center had 175 patients, of whom 127 (72.6%) were ICF/MR Program eligible.

** See glossary at end of report for definition.*

For fiscal year 2004-05, the Center had operating expenditures of $37.2 million, of which 86.7% were personnel costs (see Exhibit 2). As of June 30, 2006, the Center had 538 employees.

Audit Objectives

Our performance audit* of the Mt. Pleasant Center, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of the Center's efforts to deliver selected patient care services.

2. To assess the Center's efforts to safeguard and efficiently* use selected resources.

Audit Scope

Our audit scope was to examine program and other records related to selected operational activities at the Mt. Pleasant Center. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances. Our audit procedures, conducted from March through July 2006, included examination of Center records and activities primarily for the period October 1, 2003 through June 30, 2006.

Our audit was not directed toward examining clinical decisions made by Center staff concerning patient treatment identified within a patient's individual plan of service or expressing an opinion on those clinical decisions and, accordingly, we express no opinion on those clinical decisions. Also, we obtained information compiled by the Center (see Exhibits 1 through 3) that relates to our audit objectives. Our audit was not directed toward expressing an opinion on this information and, accordingly, we express no opinion on it.

Audit Methodology

We conducted a preliminary review of the Center's operations. This review included interviewing Center staff, reviewing applicable policies and procedures and the Mental Health Code, analyzing available data and statistics, obtaining an understanding of the Center's management control*, and conducting limited testing of transactions. We

** See glossary at end of report for definition.*

analyzed the composition of the patient population (see Exhibit 3), toured the Center's buildings, and reviewed patients' living conditions (see Exhibit 4).

To accomplish our first objective, we reviewed DCH and Center policies and procedures and met with Center staff to gain an understanding of the admission process, person-centered planning process, and discharge process. We reviewed the two most recently completed Intermediate Care Facilities for Persons with Mental Retardation certification surveys, examined patient files for compliance with the Mental Health Code and DCH and Center policies, and surveyed patients' guardians (see Exhibit 6) and Center employees (see Exhibit 7) to obtain feedback on the Center's operations. Also, we evaluated the Center's complaint process, analyzed training provided to Center staff with direct patient care responsibilities, and reviewed the Center's security systems. In addition, we reviewed the Center's records of patient deaths and serious injuries that occurred during the audit period and the Center's process to classify and investigate incidents* involving patients or employees. We also reviewed the criminal background histories of Center staff.

To accomplish our second objective, we interviewed Center staff and reviewed various DCH and Center policies and procedures. We obtained an overall understanding of and tested controls related to inventory procedures, contract management, preventive maintenance and work orders, procurement card purchases, and pharmacy practices. We reviewed equipment, supplies and materials, patient personal property, and pharmacy inventories. In addition, we reviewed the Center's most recently completed biennial internal control assessment and the Center's process for determining and billing patients a monthly charge for their share of services provided to them.

We use a risk and opportunity based approach when selecting activities or programs to be audited. Accordingly, our audit efforts are focused on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. By design, our limited audit resources are used to identify where and how improvements can be made. Consequently, our performance audit reports are prepared on an exception basis. To the extent practical, we add balance to our audit reports by presenting noteworthy accomplishments identified during our audits.

** See glossary at end of report for definition.*

Agency Responses and Prior Audit Follow-Up

Our audit report contains 12 findings and 19 corresponding recommendations. DCH's preliminary response indicated that DCH and the Center generally agreed with all 19 recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

We released our prior performance audit of the Mt. Pleasant Center, Department of Community Health (39-305-98), in March 1999. Within the scope of this audit, we followed up 7 of the 10 prior audit recommendations. The Center complied with 5 and partially complied with 1 of the prior audit recommendations. We repeated 1 of the prior audit recommendations in this report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF EFFORTS TO DELIVER SELECTED PATIENT CARE SERVICES

COMMENT

Background: Section 330.1708 of the *Michigan Compiled Laws* (part of the Mental Health Code) requires that patients are to receive mental health services, suited to their condition, in the least restrictive setting that is appropriate and available.

The Mt. Pleasant Center provides a wide variety of continuous care services to its patients, including therapeutic services, clinical support, educational activities, and discharge planning. Patient assessments are used at the time of admission to determine which care services would benefit the patients the most.

Audit Objective: To assess the effectiveness of the Center's efforts to deliver selected patient care services.

Conclusion: We concluded that the Center was moderately effective in its efforts to deliver selected patient care services. Our audit disclosed two material conditions*. The Center needs to improve its monitoring of patient services to help ensure that the Center complies with patient treatment plans, Center policy, and State law and federal regulations (Finding 1). The Center did not ensure that direct care staff received the training as required by Center policies and procedures. Also, the Center had not updated its training policies and procedures to help ensure that its training program meets the Center's operational needs. In addition, the Department of Community Health (DCH), in conjunction with the Center, had not developed an overall training strategy which would help the Center document its training practices. (Finding 2)

Our audit also disclosed reportable conditions* related to person-centered planning process, dental care, and complaints (Findings 3 through 5).

** See glossary at end of report for definition.*

FINDING

1. Center Monitoring Activities*

The Center needs to improve its monitoring of patient services to help ensure that the Center complies with patient treatment plans, Center policy, and State law and federal regulations. Improved monitoring of patient services would also help the Center identify and resolve patient service deficiencies on a timely basis and help ensure that it provides services to patients in a safe environment.

The Center operates under policy directives and operating procedures established by DCH and also under requirements specified in the Mental Health Code and the *Code of Federal Regulations* (*CFR*). These policies, procedures, and other requirements were designed to have a positive impact on the services provided to the Center's patients; to ensure that the Center provides services to patients in the least restrictive environment; and to help ensure that the Center provides a safe and secure environment for the Center's patients, staff, and other individuals.

During our audit period, several incidents occurred and the Center underwent two certification surveys that indicated that the Center had been in noncompliance with various requirements and/or had weaknesses in its monitoring of patient services. We noted:

a. Three critical incidents occurred at the Center that resulted in the injury and/or death of Center patients. These incidents involved either noncompliance with patient treatment plans, Center policies, or requirements of the Mental Health Code:

(1) During our audit period, a patient died from complications relating to aspiration pneumonia*. The Center's internal investigation of this incident concluded that the tentative cause of death was respiration failure secondary to aspiration pneumonia caused by self-induced regurgitation. However, there was no official autopsy performed.

The Center's internal investigation reported that Center staff fed the patient peanut butter on animal crackers shortly before the patient began choking. Center records disclosed that the patient was on a mechanical

* *See glossary at end of report for definition.*

soft diet. The Center's food and nutrition procedures specifically prohibit feeding peanut butter to anyone on a mechanical soft diet. Approximately two months prior to this incident, the Center's dietician sent an e-mail to all of the Center's residential units reminding Center staff that peanut butter should not be fed to patients on a mechanical soft diet. The Center's investigation concluded that dietary procedures were not followed by Center staff. Center records disclosed that the patient had a long history of regurgitation problems. The Center's investigation also concluded that the patient could have aspirated on any type of food.

(2) During our audit period, Center staff found a patient unconscious while taking a bath and the patient later died. An autopsy disclosed the patient's death was caused by a blunt force injury to the abdomen. Also, the autopsy report classified the death as a homicide. An investigation by local law enforcement officers did not identify the individual or individuals who caused the blunt force injury to the patient.

Center records disclosed that staff left the patient unsupervised in the bath for at least 20 minutes when the resident care aide (RCA) responsible for the patient left the area to attend to another patient without informing other staff that a patient was bathing. Center policy did not indicate how often staff should supervise a patient while bathing. However, Center policy required that a staff member ensure that another staff member assumes responsibility for supervising a patient whenever the first staff member leaves the location.

(3) During our audit period, a patient attacked another patient who suffered severe internal injuries. The injured patient required two surgeries to repair the injuries. DCH's Office of Recipient Rights investigated the incident and concluded that an RCA provoked the attack on the patient. The Center removed the RCA involved in the attack from direct patient service activities and later dismissed that employee. Section 330.1722 of the *Michigan Compiled Laws* states that a recipient of mental health services shall not be subject to abuse or neglect.

Although compliance with policies, procedures, and other requirements contribute to a safe and secure facility, the general nature of the Center's

patients can be unpredictable and inherently dangerous. In addition to the incidents identified above, during the period November 1, 2005 through April 30, 2006, the Center experienced 247 attempts or threats of suicide or self-harm by patients and had 259 acts of aggression by patients on other patients that resulted in 209 injuries. Therefore, compliance with the policies, procedures, and other requirements may not entirely eliminate safety and security risks. As a result, the Center and DCH need to continually monitor and evaluate patient services to help ensure the safety and security of the Center's patients, staff, and other individuals.

b. The Center is subject to annual certification surveys to ensure that it is in compliance with the requirements of the *CFR*. These surveys qualify the Center for certification as an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), which allows the Center to receive federal Medicaid reimbursement for eligible patients. The annual surveys are completed by DCH's Bureau of Health System staff (who are independent of Center operations) and approved by the U.S. Department of Health and Human Services. Our review of the surveys completed during 2005 and 2006 disclosed that the Center may have prevented instances of noncompliance with the *CFR* and Center policy by improving its monitoring of patient services. Improved monitoring would also help the Center to better serve and protect its patient population. Our review noted:

(1) The 2005 survey disclosed that during a 3-month period (from November 1, 2004 through January 31, 2005), the Center's school used a storage room as a time-out/seclusion room 4 times (involving 3 different patients). Surveyors noted that equipment in that storage room could have been potentially hazardous to patients. We also noted that Center policy does not allow the use of time-out or seclusion rooms for patients.

Surveyors indicated that local school district staff (who operated the Center's school) used the time-out/seclusion room after incidents involving the display of disruptive behavior by a patient. After each use of the time-out/seclusion room, local school district staff forwarded incident reports to the Center's quality assurance and medical staff that documented the use of the time-out/seclusion room. However, during their reviews of these 4 incident reports, both the Center's quality assurance staff and its medical staff failed to recognize that local school

district staff were using seclusion to manage patients' behavior in violation of the patients' treatment plans and Center policies and procedures.

The Center's director reported that, after being informed by the surveyors that local school district staff were using a time-out/seclusion room for Center patients, he took immediate steps to halt this practice.

The 2006 survey did not disclose the use of a time-out/seclusion room.

(2) Both surveys indicated that the Center did not obtain some guardians' consents to provide medications to patients. Surveyors disclosed that the Center failed to obtain guardians' informed consents for 3 (18.8%) of the 16 patients reviewed within the 2005 survey and 1 (100.0%) of 1 patient reviewed within the 2006 survey. Without these consents, the patients' guardians were unaware of dosage levels the Center administered to patients or of the general symptoms the Center intended to treat with the medications.

(3) Both surveys cited the Center for not providing patients services in accordance with the patients' approved treatment plans. The surveyors reported several deficiencies, including Center staff not interacting with patients as required by patient treatment plans, the Center not establishing time frames for patients to achieve objectives established within patient treatment plans, and Center staff not providing weekly training sessions as established in a patient's treatment plan.

(4) Both surveys cited the Center for not providing a sanitary environment to help ensure that it avoided sources and the transmission of infections. The surveyors reported several related deficiencies, including Center staff leaving trash bags outside of a dumpster, patients mouthing objects that came into contact with dirty floors, and patients not washing their hands after handling soiled linens.

As a result of the critical incidents and certification surveys, the Center has made some changes to its monitoring activities. However, the Center needs to ensure it timely monitors patient services functions to effectively prevent or detect patient critical incidents and to eliminate lapses in patient services.

RECOMMENDATION

We recommend that the Center improve its monitoring of patient services to help ensure that the Center complies with patient treatment plans, Center policy, and State law and federal regulations.

AGENCY PRELIMINARY RESPONSE

DCH and the Center agreed in principle with the recommendation and intend to continue efforts to improve its monitoring of patient service activities to help ensure compliance with patient treatment plans, Center policy, and State and federal laws. However, the Center informed us that given the general nature of these patients, as the finding describes, there is no level of monitoring possible that would ensure the complete elimination of incidents involving patients. While the Center certainly acknowledges that critical and unfortunate incidents involving patients occurred during the audit period, all three incidents related more to issues involving the personal actions of individual staff members for which the Center immediately initiated appropriate disciplinary action. The Center will reinforce its commitment to provide the highest possible level of care to its patients and that commitment will be communicated to its entire patient care staff. To further address this issue and the deficiencies identified in the annual certification surveys, the Center will initiate a review of all of its current monitoring programs and practices related to patient services. The Center informed us that the results of the review will be used to identify and implement revisions to its current practices as necessary to help improve efforts to serve its clients in a safe and secure environment in accordance with the patients' plan of treatment. The Center expects to complete its review by May 1, 2007.

FINDING

2. Training Practices

The Center did not ensure that direct care staff received the training as required by Center policies and procedures. Also, the Center had not updated its training policies and procedures to help ensure that its training program meets the Center's operational needs. In addition, DCH, in conjunction with the Center, had not developed an overall training strategy which would help the Center document its training practices. A documented overall training strategy would help provide some assurance that the Center provides its direct care staff with all necessary training.

Properly trained staff are essential to effectively care for the Center's patients and to enhance the safety of patients and staff. The completion of required training would help the Center improve employees' skills and safety, familiarize employees with new developments and techniques, and reinforce the employees' knowledge and understanding of their job responsibilities.

DCH informed us that each State-operated mental health facility is responsible for its own training efforts. The Center has a training department that provides the majority of the training to staff. Training is provided on a diverse range of topics focused on patient care. To help ensure that all direct care staff receive proper levels of training, DCH and the Center developed specific amounts of time that should be devoted to training for various employee classifications (e.g., nurses and RCAs).

Our review of the Center's training practices disclosed:

a. The Center did not provide the level of training specified by Center policies and procedures. We noted:

   (1) The Center's training records for all 8 (100.0%) of the 8 licensed practical nurses (LPNs) reviewed did not document that the LPNs received the required amount of annual training. The Center's master classification list requires LPNs to obtain 60 hours of annual training. The amount of training these individuals received for the fiscal year ranged from 11.9 to 29.0 hours. On average, the 8 LPNs received 18.5 hours of training (approximately 41.5 hours less than what was required).

   (2) The Center's training records for 27 (84.4%) of the 32 RCAs reviewed did not document that the RCAs received the required amount of annual training. The Center's master classification list requires RCAs to obtain 60 hours of annual training. The amount of training these individuals received for the fiscal year ranged from 9.6 to 37.0 hours. On average, the 27 RCAs received 21.4 hours of training (approximately 38.6 hours less than what was required).

   As part of our audit, we surveyed employees who had direct contact with the Center's patients (see Exhibit 7). We questioned employees on their satisfaction with the amount of training the Center provided to staff and

received responses from 24 employees. Although the majority of the 24 employees responded that they were satisfied with the training received, 11 (45.8%) were somewhat or very dissatisfied with the amount of aggressive behavior training received; 10 (41.7%) were somewhat or very dissatisfied with the amount of safety and security training received; and 9 (37.5%) were somewhat or very dissatisfied with the amount of medication distribution training received.

In addition, the Center's annual certification surveys also identified deficiencies in the Center's staff training program. The certification survey conducted in February 2005 disclosed that the Center did not meet the federal standard of providing training that focused on skills and competencies directed toward patients' developmental needs. The certification conducted in January 2006 disclosed that the Center failed to provide each employee with continuing training that enables the employee to perform their duties effectively and efficiently.

b. The Center's training policy was outdated and, in some instances, was no longer applicable to the Center. The policy, last updated in 1994, refers to procedures that no longer apply to the daily activities of the Center. Also, the policy references a rescinded section in the *Michigan Administrative Code*. In addition, the Center's policies relating to the level of training that should be provided to the different employee classifications were developed in 1980 and may not reflect the Center's current needs.

c. DCH, in conjunction with the Center, had not developed an overall training strategy that documents the type of training required by each employee classification. An overall training strategy would help the Center document its training practices and would also provide some assurance that the Center provides its direct care staff with the training required by State and federal regulations.

Both State and federal regulations require that Center employees receive appropriate training. The *Michigan Administrative Code* requires that there be a written plan for providing training. The *CFR* specifies that employees should receive training that enables them to perform their duties effectively, efficiently, and completely. DCH and the Center have developed policies and procedures over the years that provide some guidance as to how training is to be

administered. However, neither DCH nor the Center has developed an overall strategy which documents that their training programs provide the appropriate training required by State and federal regulations.

We noted similar conditions in our prior audit. In response to that audit, the Center stated that it would review and revise its policy concerning staff training to ensure that training focused on the enhancement of staff competency.

RECOMMENDATIONS

WE AGAIN RECOMMEND THAT THE CENTER ENSURE THAT DIRECT CARE STAFF RECEIVE THE TRAINING AS REQUIRED BY CENTER POLICIES AND PROCEDURES.

We also recommend that the Center update its training policies and procedures to help ensure that its training program meets the Center's operational needs.

In addition, we recommend that DCH, in conjunction with the Center, develop an overall training strategy which would help the Center document its training practices.

AGENCY PRELIMINARY RESPONSE

The Center agreed that its direct care staff did not receive the number of required hours of training as specified by the Center's policies and procedures.

The Center also agreed that its training policies and procedures need to be updated to meet current operational needs. The Center informed us that, in conjunction with DCH central office, it has taken steps to review and revise the Center's training policies and procedures to ensure that direct care staff receive appropriate training as required by State and federal regulations, and to determine what is appropriate to meet operational needs. As part of this review, DCH and the Center will review training requirements adopted by other similar health care providers to determine what is appropriate. The Center expects to have these policies and procedures updated by May 1, 2007.

FINDING

3. Person-Centered Planning Process

The Center did not complete all patients' comprehensive evaluations and person-centered plans (PCPs) on a timely basis. Also, the Center did not document that all patients were provided the opportunity to participate in all aspects of the person-centered planning process. In addition, the Center did not incorporate measurable treatment plans or discharge goals into all PCPs.

Completion of patients' comprehensive evaluations on a timely basis would help ensure that the Center is in compliance with State law and federal regulations and would also help ensure that patients receive needed services in a timely manner. Including patients within all aspects of the person-centered planning process provides the patients with the opportunity to participate in the selection of treatment and/or support services. Identifying measurable treatment plans and discharge goals provides a means for patients and staff to assess the patients' progress.

Federal regulation 42 *CFR* 483.440 states that within 30 days after admission, the interdisciplinary team must perform accurate assessments as needed to supplement the preliminary evaluation conducted prior to admission. Section 330.1712 of the *Michigan Compiled Laws* (part of the Mental Health Code) states that the individual plan of service shall consist of a treatment plan, a support plan, or both and shall address, as either desired or required by the patient, the patient's needs. The treatment plan shall establish meaningful and measurable goals with the patient. Center policy states that, within 28 days of admission, the individual plan of service is to be developed using the person-centered planning process.

We reviewed the records of 20 patients that the Center admitted between October 1, 2005 and March 31, 2006. Our review disclosed:

a. The Center did not complete all of the required assessments for 13 (65.0%) of the 20 patients within 30 days of their admission. We also noted that 18 (17.3%) of 104 assessments for these 13 patients had not been completed within 30 days of the patients' admission to the Center, including 2 that had not been done at all. The remaining 16 assessments were completed from 32 to 203 days after the patients' admission to the Center, or an average of 34.8 days late.

b. PCPs for 6 (30.0%) of the 20 patients were not completed within 28 days of admission as required. The PCPs were completed between 3 and 58 days late.

c. According to the documentation in patient files, PCPs for 3 (15.0%) of the 20 patients were developed prior to the Center completing any comprehensive evaluations of the patients' conditions. Also, there was no documentation that the patients were given the opportunity to participate in the selection of treatment and/or support services. Without this participation, the Center could not determine whether the patients' preferences and choices were considered.

d. Three (15.0%) of the 20 patients' PCPs did not include a measurable treatment plan that addressed the patients' behaviors or stated discharge goals.

RECOMMENDATIONS

We recommend that the Center complete all patients' comprehensive evaluations and PCPs on a timely basis.

We also recommend that the Center document that all patients are provided the opportunity to participate in all aspects of the person-centered planning process.

In addition, we recommend that the Center incorporate measurable treatment plans and discharge goals into all PCPs.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendations. The majority of the items cited were for PCPs related to patients that were ineligible for Medicaid reimbursement within the ICF/MR Program.

Beginning in May 2006, the determination was made by the Center that all patients are to receive planning and services utilizing the same model and expectations used for patients eligible for Medicaid reimbursement within the ICF/MR Program. The Center informed us that the person-centered planning process, including assessments and time lines, are now the same for all patients at the Center. This process is being accomplished immediately for all newly admitted persons and is being phased in for all current patients based on their PCP date. This model and

expectations include, but are not limited to, completion of comprehensive evaluations and PCPs on a timely basis, patient participation in the PCP process, and inclusion of measurable treatment plans and discharge goals.

FINDING

4. Dental Care

The Center did not complete required dental examinations on all Medicaid eligible patients. As a result, the Center could not ensure that patients received dental care as required by federal regulations. Also, the Center, in conjunction with DCH, had not developed a policy describing the procedures to follow if a patient refuses treatment.

Federal regulation 42 *CFR* 483.460 requires the Center to provide for comprehensive diagnostic and treatment services for each Medicaid eligible patient from qualified staff, including licensed dentists and dental hygienists. The Center has a dental office that completes oral examinations (including x-rays and cleanings), restoration services, oral surgery, dentures, bite guards, and most root canals.

We reviewed the Center's dental records and policies to determine if the Center provided treatment to Medicaid eligible patients on a timely basis and if the Center had procedures in place to treat patients who refused services. Our review disclosed:

a. Seven (22.6%) of 31 Medicaid eligible patients did not receive complete dental examinations within one month of admission. Federal regulation 42 *CFR* 483.460(f)(1) requires the Center to complete an oral examination within one month of admission unless another party completed an oral examination within 12 months of admission. The Center did not determine that these 7 patients had received other dental procedures.

b. Forty-one (32.0%) of 128 Medicaid eligible patients did not receive annual dental examinations. Federal regulation 42 *CFR* 483.460(f)(2) requires the Center to complete at least annual dental examinations. As of June 26, 2006, 33 (25.8%) of these 128 Medicaid eligible patients had not received complete dental examinations since November 2004. The Center informed us that the

majority of these patients needed sedation in order to complete the examination and that the Center did not have qualified staff to complete this task between January 2005 and May 2006.

c. The Center, in conjunction with DCH, had not developed a policy that describes the procedures Center staff should pursue if a patient refuses dental services. As of June 2006, dental office staff reported that the Center had approximately 10 patients who were refusing dental services. At the time of our review, the Center stated that it was in the process of reviewing options available for providing services to these patients.

RECOMMENDATIONS

We recommend that the Center complete required dental examinations on all Medicaid eligible patients.

We also recommend that the Center, in conjunction with DCH, develop a policy describing the procedures to follow if a patient refuses treatment.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and both recommendations. Many of the Center's patients require sedation for even the most basic dental procedures. The lack of annual evaluations for the majority of these patients was attributed to the Center not having the services of a dentist with the required qualifications to administer intravenous (IV) sedation. The dentist hired in July 2005 did not have the necessary qualifications to administer IV sedation until he completed the necessary training. The Center informed us that on April 30, 2006, the dentist successfully completed a six-month training class and became fully certified to administer IV sedation. The Center also informed us that routine annual dental examinations for patients requiring sedation are now being performed for those patients that consent to treatment.

In addition, the Center informed us that it has been exploring potential options for obtaining consent, i.e., education of patients, guardianship considerations, and court guidance. The Center will develop written policies and procedures for addressing these situations, which will recognize that patients do have a statutory right to refuse treatment and the Center has the obligation to honor and respect

those rights. The Center expects to have these policies implemented by May 1, 2007.

FINDING

5. Complaints

The Center, in conjunction with DCH, had not established procedures that would allow Center staff to submit complaints relating to Center operations for consideration and investigation.

Establishing a formal process for employees to submit complaints would enable the Center to obtain valuable feedback regarding staff and patient related services. The Center could use this feedback to help identify unethical employee behavior and activities, could potentially improve communications between labor and management, and may improve services provided to patients. Also, the Center could help ensure that all complaints are fully and impartially reviewed by developing criteria for handling complaints, including forwarding complaints to other units within DCH for consideration when necessary.

Center management stated that they did not believe that a separate complaint process was necessary and stated that complaints can be pursued through the Department of Civil Service rules and regulations, bargaining unit agreements, or the Center's licensing agency.

We reviewed available documentation, surveyed Center employees, and met with Center employees to obtain feedback on complaints. We noted:

a. In February 2006, DCH central office staff held meetings at the Center to address the concerns of Center staff. The Center reported that these meetings were held to address a number of complaints received by DCH from Center employees. As a result of these initial meetings, the Center and DCH agreed that DCH central office staff would do some additional monitoring of the Center, including the monitoring of Center training functions and attending labor management meetings.

b. As part of our audit, we surveyed employees who had direct contact with the Center's patients (see Exhibit 7). We questioned employees' satisfaction with

the Center's efforts to follow up and resolve complaints made by or against employees. Sixteen (66.7%) of the 24 employees responded that they were somewhat or very dissatisfied with the Center's efforts to resolve complaints made by or against employees. In addition, we received 14 written comments related to the questions presented. All 14 (100%) of the comments were critical of the Center's management and generally stated that Center management was not interested in staff feedback. Also, 20 (83.3%) of the 24 employees responded that they were somewhat or very dissatisfied with the Center's efforts to listen to and follow-up on employee suggestions and ideas for improvement. In addition, during the audit, several Center staff contacted our staff and informed us that the Center did not have a process in place to document their complaints. These employees had various complaints concerning services provided to patients.

In our recently completed performance audit of the Caro Center, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (391-0900-05), in November 2006, we noted that the Caro Center did have a formal process to document and investigate complaints.

RECOMMENDATION

We recommend that the Center, in conjunction with DCH, establish procedures that would allow Center staff to submit complaints relating to Center operations for consideration and investigation.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation. The Center informed us that formal policies and procedures for staff to submit complaints could result in valuable feedback regarding staff and patient activities. The Center will develop a formal process, in conjunction with DCH, for staff to submit written complaints and suggestions. The Center expects to have policies and procedures implemented by April 2007.

EFFORTS TO SAFEGUARD AND EFFICIENTLY USE SELECTED RESOURCES

Audit Objective: To assess the Center's efforts to safeguard and efficiently use selected resources.

Conclusion: We concluded that the Center's efforts were moderately effective in safeguarding and efficiently using selected resources. Our audit disclosed two material conditions. The Center had not established effective controls over its inventories (Finding 6). Also, the Center did not effectively complete its biennial internal control assessment (Finding 7).

Our audit also disclosed reportable conditions related to medication purchases and utilization, medication refunds and rebates, patients' personal property, inventory of noncontrolled substances, and procurement card approvals (Findings 8 through 12).

Noteworthy Accomplishments: In 1999, the Center, in conjunction with the Walter P. Reuther Psychiatric Hospital, entered into a 10-year energy management contract with a private vendor. The vendor installed equipment and systems for the purpose of reducing energy use and/or costs. The vendor charged the Center for the cost of the installation and guaranteed the Center and the Walter P. Reuther Psychiatric Hospital a minimum annual savings. For the first five years of the contract (2001 through 2005), the Center saved $883,916 over 1998 base year costs.

FINDING

6. Controls Over Inventories

The Center had not established effective controls over its inventories. As a result, the Center had not recorded balances for all inventories and thus could not account for all inventories on hand or ensure that inventories were properly controlled and safeguarded.

The Center operates a warehouse that stocks approximately 400 commodities for use at the Center, including clothing and textiles, household and office supplies, and some furniture. Also, the maintenance department uses a closed residential unit to store supplies and materials (see Exhibit 5) and the Center's central kitchen has a number of refrigerators, freezers, and storage rooms where it maintains the Center's food inventory. During fiscal year 2004-05, the Center expended $1.2

million on commodities and approximately $473,000 on food items used at the Center.

Our review of the Center's controls over its various inventories disclosed:

a. The Center did not use an inventory system to track most supplies and materials, equipment, and nonfrozen food inventory levels. Also, the Center did not conduct annual inventories of supplies and materials, equipment, and nonfrozen food items.

   Chapter 12 of the State of Michigan Financial Management Guide requires agencies, such as the Center, to establish and maintain a supplies and materials inventory control program. Chapter 12 also requires agencies to verify the accuracy of inventory systems by conducting an annual physical inventory of randomly selected portions of their inventories.

   The Center did track and inventory State-owned items that are more susceptible to theft (desirable consumer goods, such as radios, stereos, televisions, cameras, etc). The Center's accounting department maintained a listing of these items by building. However, we noted that the listing was not accurate. For example, at the warehouse, we were unable to locate 7 (46.7%) of 15 items. Also, we located 9 items in the warehouse that were listed as being maintained at other buildings and 16 items that the accounting department did not identify on the inventory listing. In addition, Center staff responded that the accounting department did not investigate differences identified between listed and located items during its annual inventory.

b. The Center had not developed written inventory policies and procedures. Written inventory policies and procedures would help ensure that employees have detailed knowledge of their responsibilities related to inventory operations. Also, written inventory policies and procedures may help minimize the disruptive impact and training costs associated with employee turnover.

c. The Center's maintenance staff did not maintain tool inventory listings. As of June 22, 2006, the maintenance department employed 13 maintenance mechanics and 4 grounds staff. The Center reported that each one of these individuals maintained a tool box and also had tools on vehicles used for maintenance activities. Maintenance staff did not maintain a formal listing of

these tools; therefore, the Center could not determine if any tools were missing.

d. The Center did not control supplies and materials used by maintenance staff. Center maintenance staff used various supplies and materials to complete necessary repairs. Maintenance staff had unsupervised access to these supplies and materials, for which the Center had not established an inventory tracking system. Also, the Center did not require maintenance staff to account for or report the amount of supplies and materials used in repairs. Therefore, the Center cannot ensure that all supplies and materials were used for repairs to State property.

e. The Center did not document the distribution of items (furniture, televisions, maintenance equipment, etc.) transferred from other State-operated facilities.

   According to its records, the Center received 543 items from the Northville Psychiatric Hospital after that facility had closed. Because the Center did not track where these items were located after they were received, we did not attempt to complete an inventory of the transferred items.

As part of our audit, we surveyed employees who had direct contact with the Center's patients (see Exhibit 7). We questioned employees on their satisfaction with the Center's efforts to safeguard its assets from loss or theft and received responses from 24 employees. Although the majority of the 24 employees responded that they were satisfied with these efforts, 9 (37.5%) were somewhat or very dissatisfied with the Center's efforts to safeguard its assets.

RECOMMENDATION

We recommend that the Center establish effective controls over its inventories.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation. The Center will establish policies and procedures that require annual physical inventories of materials and supplies, equipment, nonfrozen food items, and any items susceptible to theft.

The Center informed us that a requisition procedure will be developed to control and issue certain (to be determined by policy and procedure) materials and supplies used by maintenance staff to complete necessary repairs. The Center also informed us a list of tools issued to each maintenance person will be maintained and verified through an annual inventory. Maintenance workers will be held personally accountable for the tools issued to them and a reasonable explanation will be required before any missing tools are replaced. In addition, the Center informed us that a system will also be developed to document the receipt and subsequent distribution of items transferred from other facilities, depending on the value of the item(s) received. Items valued over $5,000 will be tagged, as will certain other items that may be susceptible to theft.

The Center added that the controls to be implemented will weigh the potential benefit to be gained against the cost of implementing the control. The Center expects to have the policies and procedures developed by May 2007.

FINDING

7. Biennial Internal Control Assessment

The Center did not effectively complete its biennial internal control assessment. As a result, the Center excluded some control activities* that it should have assessed, did not identify whether control activities adequately reduced risk associated with significant operating functions, and did not identify material conditions associated with the Center's significant operating functions.

Section 18.1485 of *Michigan Compiled Laws* requires the head of each principal department to provide a biennial report on the evaluation of the principal department's internal accounting and administrative control system. For the period reviewed, the report shall include a description of any material inadequacy or weakness discovered as of October 1 of the preceding year and the plans and a time schedule for correcting the internal accounting and administrative control system. The State Budget Director developed guidance, entitled *Evaluation of Internal Controls - A General Framework and System of Reporting*, for use by principal departments in performing and reporting upon evaluations of their internal control systems. To complete the departmental evaluation, DCH required individual

** See glossary at end of report for definition.*

assessable units (such as the Center) to assess their operations. DCH provided instructions to the assessable units on how to complete these assessments.

The Center completed its biennial internal control assessment in March 2005. Within the assessment, the Center stated that its operations encompassed 18 significant operating functions. Examples of operating functions include maintaining effective and efficient communications and maintaining a safe environment of care. An assessment of an operating function should include the review and evaluation of the control and monitoring activities relating to each specific operating function. Our review of the Center's assessment process disclosed:

a. The Center's assessment did not identify the specific control activities designed to mitigate risk for portions of 13 (72.2%) significant operating functions. For example, the control activities related to the function of maintaining fiscal and organizational efficiencies did not identify control activities for the development and operation of an inventory tracking system.

b. The Center's assessment did not identify specific monitoring activities for each control identified within the assessment. We noted 24 controls for which the Center did not identify a related monitoring activity designed to assess the effectiveness of the control. For example, the Center did not establish monitoring activities to ensure that it properly executed spending authorization controls.

c. The Center's assessment did not determine whether the control activities adequately reduced the risks associated with the individual operating functions. DCH instructions require the assessable units to state whether control activities are adequate to reduce risk. The Center did not complete this task for any of the 120 activities identified.

d. The Center's assessment activities did not identify material weaknesses in the Center's internal control over 2 (11.1%) of its 18 significant operating functions that were included in its biennial internal control assessment. During the course of our audit, we identified material weaknesses in the Center's internal control over inventory and training. These material weaknesses were not identified during the Center's biennial internal control assessment.

An effectively completed and implemented biennial internal control assessment would provide the Center with methods to reasonably ensure that the control measures identified and used by the Center safeguard its assets, provide reliable data, promote operating efficiency, and encourage adherence to prescribed managerial policies.

RECOMMENDATION

We recommend that the Center effectively complete its biennial internal control assessment.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation.

The Center informed us that individuals responsible for the assessment have attended additional training in preparation for the next assessment and have gained a better understanding of what is required. For the next assessment, specific control activities designed to mitigate risk for the various operating functions will be identified, monitoring activities for each control will be identified, and a conclusion will be specified as to whether the control activities are sufficient to adequately address the risk factors.

The Center also informed us that, with respect to subparagraph "d.", while the Center would certainly strive to identify and address material weaknesses as part of its assessment, the Center believes that it is not realistic to anticipate in advance conclusions that may be reached as a result of a complete audit conducted of the agency's operations subsequent to the completion of an assessment.

FINDING

8. Medication Purchases and Utilization

The Center did not implement controls to ensure that it efficiently purchased and used medications distributed by the Center's pharmacy. As a result, the Center could not ensure that it purchased medications at the lowest cost or prevented staff from allowing medications to expire before the Center used the item.

The Center uses the State of Michigan's contract with a pharmaceutical provider to purchase all of its medications. Each business day, the Center's pharmacist places

orders for medications through an on-line program. The Center purchases medications in various quantities (ranging from 30 to 500 counts) depending on the Center's expected needs. When received, medications are stored in the pharmacy and in an overnight cabinet. The overnight cabinet stores medications for after-hours use and emergencies. During fiscal year 2004-05, the Center expended approximately $1.84 million on medications.

During our review of pharmaceutical purchases and use, we noted:

a. The Center did not always purchase medications in the most cost-efficient quantities. The Center expended approximately $566,000 on four commonly used medications between March 6, 2005 and March 5, 2006. Our review disclosed that the Center could have saved approximately $10,000 on these medications by purchasing medications at the lowest available price. For example, the Center purchased an anti-psychotropic medication in three different quantities: 30, 60, and 100 counts. The cost to the Center per pill was $17.97, $15.84, and $16.27, respectively. The Center could have saved approximately $4,400 by purchasing this medication in 60-count quantities, which was available at a lower price.

b. The Center did not have a policy to return medications from the overnight cabinet to the pharmacy before the expiration date for redistribution. The Center allowed these medications to expire and returned them to the pharmacy to be included in the medications sent back to the suppliers for a possible refund. Returning the medications to the pharmacy before expiration would provide the pharmacy the opportunity to use the medications and avoid the need for the Center to return the medications for a potential refund.

RECOMMENDATION

We recommend that the Center implement controls to ensure that it efficiently purchases and uses medications distributed by the Center's pharmacy.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation. The Center informed us that procedures will be implemented to ensure that medications are purchased in quantities providing the best available value. The Center added that, depending on the utilization rate, purchasing medications in the largest

quantities simply because they yield the lower per unit cost does not always represent the most cost-effective method. The Center noted that carrying excess quantities or inventories has its own inherent risk and also may increase the likelihood that medications may expire before they can be utilized.

In addition, the Center informed us that the issue relating to expired medications from the overnight cabinet has been referred to the Center's Pharmacy and Therapeutics Committee and is also being addressed by the internal work group established by DCH to look at the inventory control issue. An effective inventory control program would enable the Center to better track and monitor the medication inventory in the overnight cabinet. In the interim, the Center's pharmacist will explore the possibility of reducing the number of medications available in the after hours supply cabinet and will consider instituting a regular after hours medication replacement supply program on either a weekly or monthly basis. The Center added that returns from the overnight cabinet will be returned to the regular pharmacy stock.

FINDING

9. Medication Refunds and Rebates

The Center did not reconcile refunds for medications to supporting documentation. Also, the Center did not reconcile vendor rebates with pharmaceutical sales totals. As a result, the Center could not determine if it received refunds for all returned medications or if rebate amounts were accurate.

The Center sorts expired, recalled, damaged, and unneeded medications for return by substance type (controlled and noncontrolled). The Center uses a vendor to coordinate the return of these medications to the Center's pharmaceutical suppliers. The Center ships the medications to the vendor after taking an inventory of the items to be returned. The vendor generates a manifest listing the quantity of each controlled and noncontrolled substance that it acknowledged receiving. The manifest contains an estimated amount for the returned medications, which is reconciled with the Center's inventory of medications sent. Also, the Center receives rebates from pharmaceutical suppliers through the Department of Management and Budget for the purchase of specific medications based on the amount of sales for those items over a given time period. The Center stated that it

does not have the means to determine if all rebates it was entitled to were received.

We reviewed approximately $13,800 in refunds and $46,000 in rebates due to the Center during our audit period. Our review disclosed:

a. The Center's accounting department did not compare the vendor's manifests of returned medications with the refunds that it received to ensure that it was fully refunded for all returned medications listed on the manifests.

   Our review of five refund manifests generated between June 11, 2004 and December 9, 2005 disclosed that the Center had received refunds for returned medications totaling approximately $13,800. However, based on manifest information, vendors still owed the Center approximately $3,100 for returned medications. Because the Center was unaware of this difference, it had not initiated any related collection efforts.

b. The Center's accounting department did not verify the accuracy of the $46,000 in rebates received from pharmaceutical suppliers for the purchase of specific medications. The Center's accounting department informed us that it did not realize it could use a program maintained by the Center's pharmacist to confirm sales totals for specific products to verify rebate amounts.

RECOMMENDATIONS

We recommend that the Center reconcile refunds for medications to supporting documentation.

We also recommend that the Center reconcile vendor rebates with pharmaceutical sales totals.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and both recommendations.

The Center will develop and implement procedures requiring a comparison of refunds received for returned medications to supporting documentation. The Center added that any material discrepancies will be investigated to ensure that the Center is receiving the appropriate credit. As for the rebate payments based on

purchases, the Center will verify the accuracy of any rebates received by confirming pharmaceutical sales totals. The Center informed us that procedures will be developed and implemented requiring that vendor rebates be evaluated for reasonableness by comparing the rebates total pharmaceutical sales based on the expected rebate percentage as stated in the contracts. The Center added that material differences or discrepancies will be investigated.

FINDING

10. Patients' Personal Property

The Center had not established effective controls over its patients' personal property.

Effective controls would help the Center ensure that patients' personal property is accurately accounted for and safeguarded and would help to minimize the Center's liability for lost, damaged, or stolen personal property.

Section 330.1728 of the *Michigan Compiled Laws* (part of the Mental Health Code) specifies that patients are entitled to receive, possess, and use all personal property, including clothing, unless such access is restricted in accordance with State law.

We reviewed 82 personal property records of 14 patients. Our review disclosed:

a. The Center could not locate all items listed on patients' personal property inventories. Five (6.1%) of the 82 personal property items were missing, including a laptop computer purchased for $1,899, a pair of orthopedic shoes purchased for $800, a sensory box purchased for $739, and a rocking chair purchased for $500. Also, one (1.2%) leather recliner belonging to a patient, which was purchased for $1,378, was marked with another patient's name.

b. The Center did not maintain a current inventory of each patient's personal property. The Center had disposed of 4 (4.9%) personal property items and forwarded 13 (15.9%) personal property items to the patients' parents or guardians. However, the Center could not document that those activities occurred and it did not adjust inventory listings to reflect the disposal or movement of items. Center policy states that a current inventory of personal

property (excluding clothing, toiletries, personal effects valued at less than $100, etc.) shall be maintained for each patient in the patient's unit by the clothing clerk.

c. Center staff did not comply with Center policy which required reviews of personal property every four months. The Center could not document that personal property inventories for 7 (50.0%) of 14 patients had been reviewed for accuracy during our audit period. In addition, the Center had not reviewed the personal property of 2 (14.3%) of the 14 patients, one since February 2004 and the other since January 2005.

We also reviewed the personal property inventory records of 20 patients who were admitted and 10 patients who were discharged between October 1, 2005 and March 31, 2006. The Center assigned clothing clerks to account for patients' personal property inventories upon admission and departure. Our review noted:

(a) The Center did not complete personal property inventories for 3 (15.0%) of 20 patients at the time of admission. Center staff did not inventory the personal property of 2 patients upon their arrival. Also, the personal property of 1 patient was inventoried but not recorded on the Center's admission form. When the Center recorded the patient's personal property inventory two weeks later, the inventory balances for 3 items varied from totals on the source document.

(b) Supervisory staff did not sign 4 (20.0%) of the 20 clothing and personal property inventory (upon admission) forms to verify that they agreed with the inventory quantities listed. The Center's clothing and personal property inventory (upon admission) form requires the residential unit's shift supervisor to sign the document to verify inventory totals.

(c) At discharge, the Center did not inventory the personal property of 1 (10.0%) of the 10 discharged patients to ensure that it agreed with supporting documentation. Also, for another patient, the Center did not resolve discrepancies between purchasing documents and inventory provided to the patient. In addition, the Center could not document that it returned personal property to 1 of the 10 discharged patients.

(d) The Center did not obtain signatures verifying that the personal property of 3 (30.0%) transferred patients were received by the person(s) or agency accepting responsibility for the discharged patients. The Center's clothing and personal property inventory form (completed upon departure) requires the person or agency receiving the patient's personal property to sign the form to verify receipt of the property.

Further, as part of our audit, we surveyed employees who had direct contact with the Center's patients (see Exhibit 7). We questioned employees on their satisfaction with the Center's efforts to safeguard patient inventories from loss or theft and received responses from 24 employees. Although the majority of the 24 employees responded that they were satisfied with these efforts, 9 (37.5%) were somewhat or very dissatisfied with the Center's efforts to safeguard patient inventories.

RECOMMENDATION

We recommend that the Center establish effective controls over its patients' personal property.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation.

The Center informed us that it will refine its individual property inventory policy and procedures. The Center added that the policy will increase the frequency of individual personal property inventories to one time per quarter and will require all newly admitted persons to have a personal property inventory completed on the day of their admission. The Center also informed us that when individuals are discharged or transferred from the Center, a final inventory will be conducted and the receiving agency will document that they have received the individual and their personal property. The Center expects to have these revised policies and procedures implemented by May 2007.

FINDING

11. Inventory of Noncontrolled Substances

The Center had not established effective inventory controls over all medications. As a result, the Center could not verify medication inventory levels or account for noncontrolled substances that it purchased.

To accommodate patients' medication needs, the Center operates an on-site pharmacy that orders, receives, and stocks hundreds of different prescription and over-the-counter medications, including both controlled and noncontrolled substances. During fiscal year 2004-05, the Center medication purchases totaled approximately $1.84 million, including about $1.81 million for noncontrolled substances.

Our review of the Center's inventory controls over these medications disclosed that the Center did not periodically inventory or had not developed an inventory accounting system for its noncontrolled substances, even though these medications accounted for most of its annual medication expenses.

RECOMMENDATION

We recommend that the Center established effective inventory controls over all medications.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and corresponding recommendation. The Center stated that the finding essentially reiterated the results of a DCH internal audit that was conducted regarding pharmacy operations at all of the DCH hospitals and centers. The Center informed us that a workgroup has been established to review the issue and provide recommendations for implementing an effective control program. The Center added that a joint effort among DCH, the Department of Corrections, the Department of Military and Veteran Affairs, and the Department of Information Technology involving an electronic medical care system is currently under discussion. The Center informed us that one component of this system would be pharmacy services, including the capabilities for pharmacy inventory accounting and management.

FINDING

12. Procurement Card Approvals

The Center did not ensure that cardholders obtained supervisory approval prior to completing procurement card purchases. Also, the Center did not ensure that accounting department staff approved the transaction logs used to track procurement card purchases on a timely basis.

Failure to document prior approval and post approval within a reasonable amount of time may allow for misuse or abuse of procurement cards. During fiscal year 2004-05, the Center made purchases totaling approximately $238,000 through the use of procurement cards.

The Center's procedural guidelines on procurement cards state that cardholders must make only purchases that have been given prior approval by a supervisor. In addition, the guidelines state that purchasing department staff are required to submit the transaction log in a timely manner to the accounting department.

We reviewed the Center's records from November 2005 for 92 procurement card transactions requiring prior approval. These transactions also required post approval by accounting department staff. We noted:

a. Prior approval from the cardholders' supervisor was not obtained in 70 (76.1%) of the 92 instances.

b. Post approval was not obtained within a reasonable time after purchases were made in 35 (38.0%) of the 92 instances reviewed. On average, the transaction logs of the 35 purchases were approved 110 days after the purchase was made. The 35 purchases were all made by the same cardholder. The Center had established 30 to 45 days as a reasonable time frame for approval.

RECOMMENDATIONS

We recommend that the Center ensure that cardholders obtain supervisory approval prior to completing procurement card purchases.

We also recommend that the Center ensure that accounting department staff approve the transaction logs used to track procurement card purchases on a timely basis.

AGENCY PRELIMINARY RESPONSE

The Center agreed with the finding and both recommendations. The Center informed us that it has revised its policy and procedure guidelines for procurement card purchases to require prior approval through one of the following methods:

- The department manager must submit a signed written approval to the cardholder prior to the purchase, which may be accomplished through a memorandum or an e-mail.

- Verbal approvals provided over the telephone must be followed up with a written approval from the department manager to the cardholder through either a memorandum or an e-mail within 24 hours of purchase.

The Center also informed us that procedures were implemented requiring supervisors to complete a post approval of the transaction logs within 45 days of the transaction cycle, as required by policy. The Center added that the accounting department will complete a thorough check of all purchases for each cycle to verify that all transactions are properly accounted for and reviewed. In addition, the Center informed that each cardholder and manager has received additional training on the change in policy.

SUPPLEMENTAL INFORMATION

MT. PLEASANT CENTER
Patient Admissions, Discharges, and Average Daily Census Data
For Fiscal Years 1997-98 through 2004-05

Fiscal Year	Admissions	Discharges	Average Daily Census
1997-98	54	65	207
1998-99	50	45	198
1999-2000	53	53	202
2000-01	66	88	190
2001-02	51	66	174
2002-03	85	45	176
2003-04	50	63	184
2004-05	115	99	198
8-Year Average	66	66	191

Source: Mt. Pleasant Center

MT. PLEASANT CENTER
Expenditures and Average Cost Per Patient
For Fiscal Years 2000-01 through 2004-05

	2000-01	2001-02	2002-03	2003-04	2004-05	Five-Year Average
Average number of patients	190	174	176	184	198	184
Personnel costs	$26,375,333	$26,270,773	$28,066,712	$32,749,573	$32,204,792	$ 29,133,437
Average cost per patient	$ 138,818	$ 150,981	$ 159,470	$ 177,987	$ 162,650	$ 158,334
Food services costs	$ 425,412	$ 429,717	$ 435,795	$ 518,975	$ 472,909	$ 456,562
Average cost per patient	$ 2,239	$ 2,470	$ 2,476	$ 2,821	$ 2,388	$ 2,481
Medications and medical supplies costs	$ 1,034,680	$ 1,077,642	$ 1,241,558	$ 1,675,316	$ 1,839,103	$ 1,373,660
Average cost per patient	$ 5,446	$ 6,193	$ 7,054	$ 9,105	$ 9,288	$ 7,466
Fuel and utilities costs	$ 1,411,944	$ 1,073,407	$ 1,301,831	$ 1,194,584	$ 1,289,589	$ 1,254,271
Average cost per patient	$ 7,431	$ 6,169	$ 7,397	$ 6,492	$ 6,513	$ 6,817
Travel costs	$ 152,334	$ 139,726	$ 147,550	$ 160,492	$ 138,735	$ 147,767
Average cost per patient	$ 802	$ 803	$ 838	$ 872	$ 701	$ 803
Materials, supplies, and equipment costs	$ 1,470,168	$ 1,969,742	$ 1,529,062	$ 1,369,926	$ 1,213,264	$ 1,510,432
Average cost per patient	$ 7,738	$ 11,320	$ 8,688	$ 7,445	$ 6,128	$ 8,209
Total Agency Costs	$30,869,872	$30,961,007	$32,722,508	$37,668,866	$37,158,392	$ 33,876,129
Average Cost Per Patient	$ 162,473	$ 177,937	$ 185,923	$ 204,722	$ 187,669	$ 184,109

Source: Mt. Pleasant Cener

MT. PLEASANT CENTER
Patient Census Breakdown
As of June 30, 2006

Patient Location:	Number of Patients	Percentage of Total
Building 405	73	41.7%
Building 610	50	28.6%
Building 611	48	27.4%
Leave of absence	2	1.1%
Out at community hospital	2	1.1%
Total	175	100.0%
Year of Admission:		
1966 - 1969	2	1.1%
1980 - 1985	3	1.7%
1986 - 1990	4	2.3%
1991 - 1995	18	10.3%
1996 - 2000	29	16.6%
2001 - 2005	99	56.6%
2006	20	11.4%
Total	175	100.0%
Gender:		
Male	131	74.9%
Female	44	25.1%
Total	175	100.0%
Race:		
White	119	68.0%
Black	55	31.4%
Other	1	0.6%
Total	175	100.0%
Legal Status of:		
Guardian admitted patient	131	74.9%
Court ordered	25	14.3%
Incompetent to stand trial	16	9.1%
Not guilty by reason of insanity	3	1.7%
Total	175	100.0%

Source: Mt. Pleasant Center

Exhibit 4

MT. PLEASANT CENTER
Photographs Showing an Open Residential Unit

Top photograph taken by Office of the Auditor General staff. Bottom photograph provided by the Mt. Pleasant Center.

MT. PLEASANT CENTER
Photographs Showing the Closed Residential Unit Used for Storage
As of May 18, 2006

Photographs taken by Office of the Auditor General staff.

Exhibit 6

Mt. Pleasant Center Guardian Survey Summary

Summary Overview

We sent surveys to 60 guardians of patients who were being treated by the Center as of May 30, 2006. We received 38 responses, a response rate of 63%. Our survey was forwarded to public guardians and friends and family who function as guardians. We did not forward the survey to patients who act as their own guardians.

Following is a copy of the survey that includes the number of responses received for each question. The total number of responses for each question may not agree with the number of responses reported above because some respondents provided more than one response to a question and other respondents did not answer all questions.

1. How long has the patient received services from the Mt. Pleasant Center?

   6 0 to 1 year
   13 1 to 5 years
   7 5 to 10 years
   3 10 to 15 years
   7 Greater than 15 years

2. How satisfied were you with the Center's admission process and the timeliness in which the patient received initial treatment from the Center?

   20 Very satisfied 14 Satisfied 1 Somewhat dissatisfied 0 Very dissatisfied

3. How satisfied were you with your level of involvement in the development of the most recent person-centered plan?

   17 Very satisfied 18 Satisfied 2 Somewhat dissatisfied 0 Very dissatisfied

4. When developing the most recent person-centered plan, how satisfied were you that the Center appropriately considered the patient's preferences and goals?

   22 Very satisfied 13 Satisfied 2 Somewhat dissatisfied 0 Very dissatisfied

5. How satisfied are you with the type, amount, and quality of treatment the patient receives at the Center?

   16 Very satisfied 19 Satisfied 3 Somewhat dissatisfied 0 Very dissatisfied

6. Do you believe that the Center treats the patient with respect and dignity?

   37 Yes 1 No

7. How satisfied are you with the Center's efforts to protect the patient's rights to privacy and confidentiality?

   22 Very satisfied 15 Satisfied 1 Somewhat dissatisfied 0 Very dissatisfied

8. Are you informed in a timely manner (within 72 hours of the event) of:

a. Changes in the patient's treatment plan?

36 Yes 1 No 0 I am not informed. 1 Not applicable

b. Changes in the patient's medications?

36 Yes 0 No 2 I am not informed. 1 Not applicable

c. Changes in the patient's physical condition?

35 Yes 2 No 1 I am not informed. 0 Not applicable

d. Details surrounding the use of restraints and the amount of time the restraints were applied?

35 Yes 0 No 0 I am not informed. 3 Not applicable

e. Aggressive behavior involving the patient that resulted in the Center conducting an investigation?

29 Yes 2 No 1 I am not informed. 5 Not applicable

9. How satisfied are you with the promptness in which the Center addresses your complaints and concerns regarding the patient's treatment?

20 Very satisfied 10 Satisfied 1 Somewhat dissatisfied 2 Very dissatisfied

5 Not applicable (I have not had any complaints or concerns regarding the patient's treatment.)

10. How satisfied are you with the Center's efforts to protect the patient's personal safety while he/she receives treatment at the Center?

18 Very satisfied 18 Satisfied 2 Somewhat dissatisfied 1 Very dissatisfied

11. Has the patient ever been involved in an incident(s) that resulted in the patient being injured?

28 Yes 8 No

Do believe the incident(s) could have been prevented?

7 Yes 20 No

12. How satisfied are you with the Center's handling of the patient's personal funds?

21 Very satisfied 13 Satisfied 3 Somewhat dissatisfied 0 Very dissatisfied

13. How satisfied are you with the Center's efforts to properly account for and safeguard the patient's personal property?

15 Very satisfied 16 Satisfied 4 Somewhat dissatisfied 2 Very dissatisfied

Exhibit 7

Mt. Pleasant Center Employee Survey Summary

Summary Overview

We sent surveys to 60 employees whose position causes them to have regular contact with patients who were being treated by the Center as of May 30, 2006. We received 24 responses, a response rate of 40%. Our survey was forwarded to resident care aides and professional employees who have direct daily contact with patients.

Following is a copy of the survey that includes the number of responses received for each question. The total number of responses for each question may not agree with the number of responses reported above because some respondents provided more than one response to a question and other respondents did not answer all questions.

1. How long have you been employed at the Mt. Pleasant Center?

   8 1 to 5 years
   6 5 to 10 years
   2 10 to 15 years
   8 Greater than 15 years

2. How many hours per shift are you in direct contact with patients?

   2 1 to 3 hours
   2 3 to 5 hours
   20 5 to 8 hours
   0 I am not in contact with patients.

3. How satisfied are you with the Center's efforts to provide a safe and secure environment for staff and patients?

   1 Very satisfied 6 Satisfied 11 Somewhat dissatisfied 7 Very dissatisfied

4. How satisfied are you that the Center has appropriate staffing levels to safely handle the patient population?

   0 Very satisfied 7 Satisfied 8 Somewhat dissatisfied 9 Very dissatisfied

5. How satisfied are you with the amount of training provided on:

   a. Aggressive behavior?

   0 Very satisfied 13 Satisfied 2 Somewhat dissatisfied 9 Very dissatisfied

   b. Restraints?

   0 Very satisfied 17 Satisfied 3 Somewhat dissatisfied 4 Very dissatisfied

   c. Medication distribution?

   0 Very satisfied 12 Satisfied 3 Somewhat dissatisfied 6 Very dissatisfied

   d. Safety and security?

   0 Very satisfied 14 Satisfied 4 Somewhat dissatisfied 6 Very dissatisfied

   e. Handling patient inventories?

   0 Very satisfied 16 Satisfied 2 Somewhat dissatisfied 4 Very dissatisfied

6. Should any other training be provided to enhance your skills to serve patients?

12 Yes 11 No

7. How satisfied are you with the Center's efforts to safeguard the Center's assets (equipment, materials, supplies, electronics, food, etc.) from loss or theft?

0 Very satisfied 15 Satisfied 6 Somewhat dissatisfied 3 Very dissatisfied

8. How satisfied are you with the Center's efforts to safeguard patient inventories (personal belongings) from loss or theft?

0 Very satisfied 15 Satisfied 8 Somewhat dissatisfied 1 Very dissatisfied

9. Do all Center staff treat patients with respect and dignity?

17 Yes 7 No

10. How satisfied are you with the amount of treatment the Center provides patients in relation to their physical and mental conditions?

0 Very satisfied 13 Satisfied 6 Somewhat dissatisfied 5 Very dissatisfied

11. How satisfied are you with how the Center follows up and resolves complaints related to patient care?

2 Very satisfied 15 Satisfied 2 Somewhat dissatisfied 5 Very dissatisfied

12. How satisfied are you that the Center treats employees in a professional manner?

0 Very satisfied 6 Satisfied 4 Somewhat dissatisfied 14 Very dissatisfied

13. How satisfied are you with the Center's efforts to listen to and follow up on employee suggestions and ideas for improvement?

0 Very satisfied 4 Satisfied 9 Somewhat dissatisfied 11 Very dissatisfied

14. How satisfied are you with the Center's efforts to follow up and resolve complaints made by or against employees?

0 Very satisfied 8 Satisfied 6 Somewhat dissatisfied 10 Very dissatisfied

15. Does the Center utilize a continuous quality improvement (CQI) process? (A CQI process is an ongoing effort by an agency to monitor and improve the quality and effectiveness of the services that it provides.)

9 Yes 12 No

GLOSSARY

aspiration pneumonia	The inflammation of the lungs caused by inhaling amounts of foreign material, such as food, liquid, vomit, or mucus into the lungs.
CFR	*Code of Federal Regulations.*
control activity	The execution of policies and procedures that were established to help ensure that actions to address risks are effectively carried out.
CQI	continuous quality improvement.
DCH	Department of Community Health.
developmental disability	A severe, chronic condition that is attributable to a mental or physical impairment or a combination of mental and physical impairments; manifests before the individual is 22 years old; and is likely to continue indefinitely. The condition results in substantial functional limitations of major life activities.
effectiveness	Program success in achieving mission and goals.
efficiently	Achieving the most outputs and outcomes practical with the minimum amount of resources.
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation.
incident	An event involving an individual served by the Center or any employee relating to indications or allegations of criminal actions, injury, negligence, exploitation, abuse, or clinical mismanagement; an unforeseen event that presents danger to the safety or well-being of individuals served and/or employees; or a newsworthy event.

IV	intravenous.
LPN	licensed practical nurse.
management control	The plan of organization, methods, and procedures adopted by management to provide reasonable assurance that goals are met; resources are used in compliance with laws and regulations; valid and reliable data is obtained and reported; and resources are safeguarded against waste, loss, and misuse.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
mental illness	A substantial disorder of thought or mood that significantly impairs an individual's judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
mission	The agency's main purpose or the reason that the agency was established.
monitoring activity	The assessment of the design and operation of internal control.
PCP	person-centered plan.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.

person-centered planning process	A process for planning and supporting the patient receiving services that builds upon the patient's capacity to engage in activities that promote community life and considers the patient's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals, as the patient desires or requires.
RCA	resident care aide.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.

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